

**~NUTRITIONALS ~**  
**ORAL NUTRITION TAKEN BY MOUTH**  
 Prior Authorization Request Form

Effective February 2002, Vermont Medicaid established coverage limits and criteria for prior authorization of Nutritional supplements. These limits and criteria are based on concerns about safety and appropriate use. In order for beneficiaries to receive coverage for nutritionals, it will be necessary for the prescriber to telephone or complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

**Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549**

**Prescribing physician:**

 Name: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Fax #: \_\_\_\_\_  
 Address: \_\_\_\_\_

**Beneficiary:**

 Name: \_\_\_\_\_  
 Medicaid ID #: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_  
 Contact Person at Office: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Baseline: Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_

Current: Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_

Children: \_\_\_\_\_ Mid-Upper Arm Circumference: \_\_\_\_\_ Head Circumference: \_\_\_\_\_

Laboratory Values: Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Albumin: \_\_\_\_\_ Pre-Albumin: \_\_\_\_\_

**Answer the following questions:**

|   |   |
|---|---|
| Caloric/protein intake is <u>not</u> obtainable through regular liquefied or pureed foods.  | <input type="checkbox"/> Agree <input type="checkbox"/> Disagree  |
| Requested nutritional supplement will be taken by <u>mouth</u> (not administered via tube feeding)  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| Oral nutritional supplement is being requested due to:  | <input type="checkbox"/> Unplanned weight loss (see complete definition by age in clinical criteria manual)<br><input type="checkbox"/> Low serum protein levels (nutritional deficiency as defined by albumin or pre-albumin levels) |
| <b>Underlying cause of unplanned weight loss or low serum protein levels:</b><br><b>Circle or describe specifics:</b> <ul style="list-style-type: none"> <li>Increased metabolic need resulting from severe trauma (i.e.: burns, infection, major bone fractures)</li> <li>Malabsorption syndrome (as related to cystic fibrosis, renal disease, short gut syndrome, Crohn's disease and other unspecified disorders of the gut)</li> <li>Nutritional wasting due to chronic disease (i.e.: cancer, AIDS, conditions resulting in dysphagia, pulmonary insufficiency, renal disease)</li> </ul> | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |

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|   |   |
|---|---|
| <ul style="list-style-type: none"> <li>Other: Explain:           <br/>_____           <br/>_____           <br/>_____         </li> </ul> | <div> <input type="checkbox"/> Yes           <input type="checkbox"/> No         </div> |
| Additional clinical information to support PA request:<br><br><br><br><br><br><br><br><br><br>  |   |

|   |
|---|
| <b>Requested Supplement:</b> _____                    |
| <b>Strength &amp; Frequency:</b> _____                |
| <b>Anticipated duration of supplementation:</b> _____ |

Prescriber Signature: \_\_\_\_\_
 Date of this request: \_\_\_\_\_